HEALTH CARE REFORM
(Part 1)

HEARING

BEFORE THE

COMMITTEE ON ENERGY AND COMMERCE HOUSE OF REPRESENTATIVES

ONE HUNDRED THIRD CONGRESS

FIRST SESSION

ON

PRESIDENT CLINTON'S PROPOSAL TO REFORM THE NATION'S HEALTH CARE SYSTEM

SEPTEMBER 28, 1993

Serial No. 103–59

Printed for the use of the Committee on Energy and Commerce

U.S. GOVERNMENT PRINTING OFFICE

75-977CC WASHINGTON : 1994

For sale by the U.S. Government Printing Office
Superintendent of Documents, Congressional Sales Office, Washington, DC 20402
ISBN 0-16-043569-2

COMMITTEE ON ENERGY AND COMMERCE

JOHN D. DINGELL, Michigan, *Chairman*

HENRY A. WAXMAN, California
PHILIP R. SHARP, Indiana
EDWARD J. MARKEY, Massachusetts
AL SWIFT, Washington
CARDISS COLLINS, Illinois
MIKE SYNAR, Oklahoma
W.J. "BILLY" TAUZIN, Louisiana
RON WYDEN, Oregon
RALPH M. HALL, Texas
BILL RICHARDSON, New Mexico
JIM SLATTERY, Kansas
JOHN BRYANT, Texas
RICK BOUCHER, Virginia
JIM COOPER, Tennessee
J. ROY ROWLAND, Georgia
THOMAS J. MANTON, New York
EDOLPHUS TOWNS, New York
GERRY E. STUDDS, Massachusetts
RICHARD H. LEHMAN, California
FRANK PALLONE, JR., New Jersey
CRAIG A. WASHINGTON, Texas
LYNN SCHENK, California
SHERROD BROWN, Ohio
MIKE KREIDLER, Washington
MARJORIE MARGOLIES-MEZVINSKY, Pennsylvania
BLANCHE M. LAMBERT, Arkansas

CARLOS J. MOORHEAD, California
THOMAS J. BLILEY, JR., Virginia
JACK FIELDS, Texas
MICHAEL G. OXLEY, Ohio
MICHAEL BILIRAKIS, Florida
DAN SCHAEFER, Colorado
JOE BARTON, Texas
ALEX McMILLAN, North Carolina
J. DENNIS HASTERT, Illinois
FRED UPTON, Michigan
CLIFF STEARNS, Florida
BILL PAXON, New York
PAUL E. GILLMOR, Ohio
SCOTT KLUG, Wisconsin
GARY A. FRANKS, Connecticut
JAMES C. GREENWOOD, Pennsylvania
MICHAEL D. CRAPO, Idaho

ALAN J. ROTH, *Staff Director and Chief Counsel*
DENNIS B. FITZGIBBONS, *Deputy Staff Director*
MARGARET A. DURBIN, *Minority Chief Counsel/Staff Director*

CONTENTS

HEALTH CARE REFORM

TUESDAY, SEPTEMBER 28, 1993

HOUSE OF REPRESENTATIVES,
COMMITTEE ON ENERGY AND COMMERCE,
Washington, DC.

The committee met, pursuant to notice, at 1 p.m., in room 2123, Rayburn House Office Building, Hon. John D. Dingell (chairman) presiding.

The CHAIRMAN. The committee will come to order.

Today the committee is honored and happy to launch its hearings on the President's health care reform proposal. We welcome today most warmly the First Lady, Mrs. Hillary Rodham Clinton, as the lead-off witness in these hearings and as lead-off witness on behalf of the administration.

Before we begin, the Chair wishes to address a few housekeeping matters. These were outlined in the memorandum which I sent to my colleagues yesterday, but for the record they will be repeated. First, the Chair will not be making an opening statement today and other opening statements today will be dispensed with so that the time that the committee has can be used by Mrs. Clinton in the most efficient and best fashion.

Members may insert written statements for the record if they so desire and, without objection, all members will be afforded rights at this time to insert an appropriate opening statement in the record.

[The following statements were submitted:]

STATEMENT OF HON. BILL RICHARDSON

Mr. Chairman, I would like to welcome the very distinguished First Lady to our committee today and thank her for her incredible dedication to one of the most complex tasks facing our Nation today. Your work on health care reform has been nothing short of spectacular, and it is my hope that you will continue to play a large role in working with Congress to get badly needed legislation passed.

This is the first of what will likely be a series of hearings on one of the most comprehensive plans for legislation ever presented to Congress. That fact alone makes these hearings very important. We must carefully examine the details of this plan to make sure the problems of our health care system are carefully addressed and remedied in the best manner possible.

Mr. Chairman, I am very encouraged by the efforts of the First Lady's health care task force to return fairness to our currently unjust system. I am particularly pleased by the task force's work in two areas: helping the employees of small businesses get health insurance, and helping the people in rural areas get better access to health care.

I believe the biggest problem in our current system is the people who currently lack adequate health care coverage. We really don't know just how many uninsured people there are. The most commonly cited figure is 37 million but we also know that millions of others lack secure coverage to keep them from being easily dropped by insurance companies.

My home State of New Mexico has the highest rate of uninsured people in the country. Some estimate that as much as a third of the population of New Mexico lacks health insurance. In a society that prides itself on fair and equitable treatment for all, I don't think the number of uninsured people in this country helps build our case. It only hurts us.

Now, we have also come to the realization that people without insurance coverage prevent us from ever getting a grip on health care costs. People without insurance coverage will likely receive health care at some point and often under the most expensive conditions. These exorbitant costs that are not affordable to the uninsured have simply been passed on to those with insurance through higher prices for insurance and health care. This practice must stop.

In my State, just as with the rest of the country, a surprising number of the uninsured are employees or dependents of employees who work for small businesses. I have talked to the employers of these people and they have told me that they cannot afford health insurance for their employees.

These business men and women are often responsible for some of the most innovative ideas and products in this country. Yet, because they have been unable to attract and keep employees due to the inability to offer insurance benefits, these driving forces of our economy have been slowed.

The part of this plan that requires businesses to pay a portion of their employees' benefits will likely receive many negative attacks. I will admit that many of my own constituents have expressed concerns with this aspect of the plan, but we must not forget the inequitable treatment of businesses under our existing system. Big business is able to negotiate better deals on insurance at the expense of small business. This plan will treat all businesses much more fairly.

I am also encouraged by the design of this plan to try to make the delivery of health care more equitable. Under the current system, most of the graduates of medical schools go into specialized medicine and usually set up shop in urban areas of the country.

In my home State, there are four standard metropolitan statistical areas (SMSA's) and over half of the counties are classified as "frontier." In most of my State, we have great difficulty recruiting enough physicians. Currently, there are very few incentives for physicians to locate in rural areas.

Fortunately, you have addressed part of that problem by adding to the incentives for physicians to locate in rural areas. You have also made changes to our system of training physicians to try to increase the number of primary-care physicians, who tend to locate more frequently in rural areas than do specialists. I applaud these changes.

I will continue to carefully monitor changes to The Health Security Act of 1993 that affect the delivery of health care to rural areas. People in rural areas must have the same access to health care that other people in our country enjoy. This is one of my litmus tests for supporting this reform plan.

This plan deserves praise for providing an excellent start on the road to passing sensible reform legislation. I am looking forward to the hearings that we have planned and trust that there will be opportunities to closely examine the details of The Health Security Act of 1993.

STATEMENT OF HON. DAN SCHAEFER

Thank you, Mr. Chairman. As we begin the task of reforming our country's health system, there is no doubt that the job before us is a daunting one. Health care is one of the largest sectors of our national economy, accounting for 14 percent of our Gross National Product—$900 billion each year.

There is no doubt that reforms are needed. There are many problems with our current way of providing and financing health care: runaway medical inflation, overwhelming malpractice liability, administrative inefficiencies, and the difficulties of ensuring health insurance to under- and un-insured populations. Identifying the problems is fairly easy. Nearly everyone voices agreement that these are areas that must be addressed.

The problem is recognizing the appropriate cure. As we in Congress begin making the difficult choices we must on the specific provisions of a comprehensive reform package, it is crucial that we maintain some historical perspective.

Many of us remember the passage of the Medicare Catastrophic Health Care Coverage Act in 1988. That legislation was intended to provide long-term health care coverage for older Americans and to fill a large gap in our current health care needs. It passed by a significant margin—the final vote in the House was 328 in

favor and 72 against. I was one of those lonely 72 votes. I felt that we were taking the wrong road to get to the right goal.

The 72 ended up being right on target. The new catastrophic coverage law was an unparalleled disaster. A year later, the same House which so overwhelmingly voted for the bill, voted by a 349-57 margin to repeal the law. That attempt at health care reform was an utter failure.

It is important to keep our experience with the catastrophic bill in mind as we approach this current debate on reform. The situation is remarkably similar. We have a legitimate problem, and nearly everyone agrees on the need for changes. The stakes in this effort, however, are a lot higher than they were in 1988.

The present reform debate sweeps across every facet of health care—from cradle to grave. Every aspect is covered, from pre-natal care, to emergency services, to long-term care. It is an exponential increase from our considerations in the catastrophic care legislation—that bill impacted only a small sliver of the entire health care system. Yet I fear that the same elements which fueled that debate will also fuel this one. I fear that Congress may blindly go where no one has gone before in our rush to "do something" on health care reform. Our past experience has already proven the futility of this approach.

There is a great passion on this debate. Emotions run high, and there are plenty of heart wrenching examples which point out the need for change. But not in Congress, and certainly not in this committee, should emotions be the ruling factor in our decisionmaking. This is the place for reasoned debate. And a reasoned debate will be guided by three primary principles.

The first is cost. There is no doubt that high costs and excessive cost increases are eating away at our health care system. Congress must take aggressive steps to rein in the escalating expenditures in health care. This can be done in a number of ways—through administrative reforms, through revamping our Nation's medical malpractice laws and through changes to antitrust laws which restrict health providers' abilities to lower costs.

These are positive changes which will pay off positive dividends. Raising taxes and capping doctors' fees will not stop runaway costs. These steps only affect the symptoms, not the disease itself. We should take the steps I and others have outlined to cure the disease.

The second main principle is access. Every American should have ready access to quality health insurance. For a number of reasons, however, millions of American citizens currently do not have insurance to cover their medical costs. Many others are excluded from coverage for preexisting conditions. We must take steps to reduce this number. Through small-group insurance reforms, by ensuring portability of insurance from one employer to another and by making health care more affordable for all Americans, we can increase access. We can ensure that, one way or the other, every American citizen will be able to get in the door of a medical clinic or hospital without fear of being bankrupted. We can ensure security.

The last principle is quality. Americans today enjoy the best medical system in the world. Our technology is superior to any other country on earth. Access to care is nearly immediate in most cases, and far better and quicker than access in countries with nationalized systems. Medical innovation in the United States is unequaled. On these points, there is also little argument.

The quality issue has not received a great deal of attention in the current debate. This is unfortunate, because I feel it is an area which will greatly suffer under some of the reform proposals before us. In reducing costs and increasing access, we must not sacrifice the quality of the health structure Americans now enjoy. We must not stifle innovation in scientific research and development.

These are the principles we must keep in mind as the reform debate swirls around us. We in this committee and in Congress must keep our eyes on these goals, instead of on the emotional arguments which will be thrust upon us. This is our responsibility to all Americans.

This is not a task to be taken lightly. The decisions this committee makes will change the course of our Nation. They will affect the lives of every single man, woman and child in America. With this sobering reality in mind, let us embark on the task before us.

Thank you, Mr. Chairman.

Statement of Hon. Blanche M. Lambert

Mr. Chairman, first allow me to thank you and your staff for rapidly putting together this timely hearing on the President's health care reform proposal. I know we can learn much from our distinguished guest, Mrs. Clinton.

Mrs. Clinton, I would like to thank you for all of your hard work in heading up the Nation's efforts to fix our beleaguered health care system. In reference to your health security plan, there is much I would like to commend you on, and there are other areas which I believe need further resolution.

Regarding the areas I would like to complement you on, I am extremely pleased that the President has chosen to include the issue of 100 percent tax deductibility of moneys spent for the purchase of health insurance by self employed individuals. As you may know, I introduced H.R. 2336 sometime ago to achieve this goal. By allowing small mom and pop businesses and American farmers the same tax opportunities as large corporate America, we will go a good distance in leveling the insurance purchasing playing field and will encourage people to make responsible health choices.

I am also impressed with the vast comprehensive basic benefits package and insurance marketplace reforms you have proposed. Citizens of the United States should be impressed with the depth and comprehensiveness of your proposals.

But I am concerned that some areas are not being fully handled by your ideas. Malpractice reform in my opinion needs to have more attention. Though you have suggested a cap on fee percentages awarded to attorneys and tried to funnel more cases to alternative dispute resolution, I believe other avenues need further exploration.

In addition, though many recommendations are made to assist rural caregivers, I believe some issues need greater concentration. For example, hospitals in my district are concerned about the lack of safeguards in place that will enable them to treat high revenue patients who are usually referred to tertiary care facilities. While I am aware that some facilities will remain nationally respected specialist institutions, I do believe rural hospitals cannot lose their gate-keeping care-giver role.

One final area of concern involves people who need to cross State lines to receive their health care. I believe that we must guarantee health alliance access for my constituents who find it easier to drive to Memphis, Tenn., or Clarksdale, Minn., instead of driving all the way to Little Rock, Ark.

Mrs. Clinton, I believe you have provided Congress with a tremendous working document to overhaul our sputtering health care system. Mr. Chairman, Mrs. Clinton, and members of this committee, I look forward to working with you all to perfect this plan so that we can continue to have a quality health care delivery system here in the United States that will be cost effective and afford men and women the ability to make responsible health related decisions.

The CHAIRMAN. Opportunity will be available later for members to make oral opening statements at a future hearing. The Chair wishes to thank the members for their cooperation on this point.

Second, in order to enable the broadest possible participation of members today, it is the intention of the Chair to observe the rules of the committee strictly because Mrs. Clinton's time with us today is most limited. I know members will be fair to their colleagues who are waiting patiently for an opportunity to question Mrs. Clinton by limiting their dialogue with the witness to the allocated time.

Finally, consistent with Committee Rule 4(c), members present at the time the hearing was called to order will be recognized in order of seniority alternating as is the custom between the Majority and the Minority. In light of the fact that we have two subcommittees that will be working on this legislation, the Chair will treat the chairwoman and the ranking minority member of the Commerce Subcommittee, Mrs. Collins and Mr. Stearns, as having seniority immediately following that of Mr. Waxman and Mr. Bliley respectively.

The rule also provides that members not present at the hearing when it was called to order will be recognized in order of their appearance and staff will be making careful note of the arrival of members for this purpose. The Chair wants to thank the members of the committee for their cooperation.

The Chair thanks you, Mrs. Clinton, for your patience and for your being present with us today. This is a rare occasion for you and for the committee. You are only the third First Lady in history to testify before the Congress and this is the first time since 1986 that we have convened a full committee hearing, which we have done to hear you. We are honored to have you here today.

I understand that you are appearing today without a formally prepared text so you are invited to proceed in any manner that you deem appropriate.

STATEMENT OF FIRST LADY HILLARY RODHAM CLINTON

Mrs. CLINTON. Thank you, Mr. Chairman.

I want to thank you and the members of this committee for giving me this opportunity, but more than that, I want to thank you for the time that you have spent with me over the last months as we have worked through a lot of the issues that will affect the future health care well-being of our country. I would also particularly like to thank the chairman for the good counsel that he has given to me as I have pursued the issues related to health care reform.

I think that is very appropriate for the chairman to have done because as we all know, 50 years ago the chairman's father introduced the Dingell-Murray-Wagner bill, the first national health insurance legislation ever put before the Congress. The chairman's father understood the importance of providing health security for all Americans. He fought vigorously to keep the ideas alive in Congress for 15 years, and you, Mr. Chairman, have continued that fight by introducing similar legislation in every session since you succeeded your father in the House of Representatives. You both proved to be men ahead of your time.

Although part of your father's bill has been incorporated into subsequent reform efforts such as Medicare and Medicaid, we have yet to fulfill your father's dream and the dreams of many other Americans of providing comprehensive health care for all of our citizens.

Health care reform is not a new idea nor a revolutionary concept, but while most Americans favor reform, we have failed as a Nation to make much progress when it comes to providing health security for every citizen. Sadly health reform in this country is less a story of the typical "American can do" attitude than a story of procrastination and parochialism and too often greed, fraud, waste and abuse.

Thomas Jefferson was the first President to talk about the importance of individual health. Franklin Roosevelt hoped that health security would be the other half of the social security system, but political realities forced President Roosevelt to discard that dream and the result, as we know, has been ongoing insecurity for millions of hard-working Americans.

When Harry Truman campaigned for a comprehensive health program in 1945, he told Congress "Millions of our citizens do not now have a full measure of opportunity to achieve and enjoy good health. Millions do not now have protection or security against the economic effects of sickness." But President Truman's pleas for health security fell victim to the politics of the day and scares about socialized medicine.

Dwight Eisenhower came before the Congress in 1955 and said that health insurance could be improved by expanding the scope of the benefits provided. John F. Kennedy proposed expanding coverage to the elderly and the mentally ill. By the early 1960's, both Presidents Eisenhower and Kennedy could not say that their hopes of health security had gone forward, but instead they saw once again the familiar sight of a dream of health security being stalled by outside interest groups and partisan bickering in the Congress.

Then came Presidents Lyndon Johnson, Richard Nixon and Jimmy Carter. There was progress made on Medicare and Medicaid. President Nixon came forward with a comprehensive health care reform proposal that built on the employer-employee system. President Carter proposed a number of advances and particularly Mrs. Carter championed the cause of mental health benefits. They, too, envisioned reforms that would give Americans more health securities and our Nation more economic security. But like their predecessors, their efforts and their hopes were not realized.

So here we are in 1993, 50 years after the chairman's father introduced the first legislation. We are still wrestling with many of the same issues and the same problems that previous generations have worked on. The difference is that today our system has many problems that have gotten increasingly expensive and the difficulty of delivering health care in a cost-effective way is challenging the fiscal integrity of the Federal and State governments, businesses, and individuals across the country.

Now is our chance to beat the historical odds and give the American people the health security they need and deserve. For the past 12 years, this committee has fought to extend health care benefits to every American. For years this committee has tried to root out fraud and abuse in the health care system. For years this committee has been ahead of its time. Now I hope that all of our time has come.

I hope that this committee, building on its rich tradition and many contributions, will help this President and this Congress and this country pass health reform legislation so that we can control health care costs and provide every American with affordable, high-quality medical care. I hope that during this session of Congress we will finally give Chairman Dingell's father the tribute he deserves. I hope that this committee will see the realization of the work it has done, but most importantly, as public stewards, the people you represent will know that their government has listened and heard and acted on their behalf.

Thank you very much, Mr. Chairman.

The CHAIRMAN. Mrs. Clinton, the committee thanks you for a very fine statement, one which I take great pride and pleasure in your mentioning my old dad who would have been proud to hear you say these things today. It was his hope and his dream and his prayer that we would one day provide a decent measure of health security in this country for all of our people, and I am sure that he would have been very proud that you were taking the leadership on it and he would be very pleased that you had mentioned him today as indeed am I. I am only going to say that I intend to do my best to help you push through the best possible form of health

security legislation for all the people at the earliest time, and you have my pledge to that.

Having said that, the Chair is going to recognize my colleagues for questions in the order in which the rules prescribe. The Chair will recognize then for 5 minutes first the gentleman from California Mr. Waxman, chairman of the subcommittee.

Mr. WAXMAN. Thank you, Mr. Chairman.

Mrs. Clinton, I am really delighted to see you here. My father just passed away as did yours. When we started going through his papers, we found a letter he wrote around 50 years ago complaining about the fact that a doctor wouldn't come to see my mother because he couldn't afford to pay the bill. She suffered for the rest of her life because of an illness that might have been controlled. So I know it was my father's dream as well and others around this country that we finally have guaranteed access to care for all Americans. That is what the core of the President's proposal is all about.

All of us who have worked for health reform for a long time have felt that we needed a President who was willing to take bold leadership to deal with this difficult issue. I used to think that was enough. Now I know we needed also a First Lady like yourself to give us the expertise and guidance you have given us in preparing this plan.

The crux of the whole issue is that everybody must get a comprehensive set of benefits. Your proposal would have us do that through the jobs site, through employer-employee contributions. Everybody is giving lip service to universal coverage, but some are saying employers ought to just offer it without making a contribution.

Others say that we ought to require each individual to go out and buy insurance and, again, no requirement that employers play any role. How is it that you came to this conclusion that we needed to require employers, large and small, and all employees to participate in paying for health insurance?

Mrs. CLINTON. Mr. Waxman, I think that you have pointed out one of the critical features of the President's plan for all the members of this committee who have struggled with the cost of health care and how we would achieve universal coverage. There are only three general ways to approach this and we have looked at all three.

The first would be a large broad-based tax that would replace the existing private sector contributions. That would mean it would replace the existing employer-employee system and any individual contributions. For a number of reasons the President rejected any kind of broad-based tax that would substitute for the system that we currently have.

A second possibility that you alluded to is to put the burden on individuals, as some States currently do with respect to auto insurance, to essentially mandate that individuals would be responsible for their own health care insurance. In order to make that affordable there would be some insurance market reforms and some kind of financial payments to low-wage individuals who otherwise could not afford it.

We looked very closely at that and we are continuing to work with those who advocate that position, particularly the Senate Republicans who have advocated an individual mandate, but we have a number of questions about it. We worry that it would undermine the existing employer-employee system in which, on a voluntary basis as a matter of either collective bargaining or employer choice or competitive purposes, employees have responded over the last decade in increasing numbers to provide health insurance.

That employer-employee system has served as the basis for insuring more than 90 percent of the people in this country who have private insurance and we worry that shifting the burden wholly over to the individual would result in many employers who currently insure ceasing to do so or maybe only insuring their high-wage workers and not their low-wage workers, and we worry that if we subsidize individuals below a certain income level that there would be pressure on employers to keep wages below the subsidy level so that they would continue to be paid for by the government.

We have a number of problems with the individual approach. We concluded that what we want to do is preserve what is right about our system and fix what is wrong. We think one of the things which is right is the employer-employee system, which does work well for most Americans. Its biggest problems have been that the cost of insurance has made it more and more difficult for many businesses to be able to participate.

If you build on the employer-employee system, you are already building on what is available and familiar to most Americans and if you do as we propose to do, to provide discounts for small businesses and to subsidize low-wage workers, we think that is the fairest and most responsible way to get everybody into the system and it is a system that is already working for most Americans and that is among the reasons why we concluded it would be the best approach for us to take at this time.

Mr. WAXMAN. Thank you very much.

The CHAIRMAN. The time of the gentleman has expired.

The Chair recognizes now the gentleman from Virginia, Mr. Bliley, the ranking minority member of the subcommittee, for purposes of questions.

Mr. BLILEY. Thank you, Mr. Chairman.

Mr. Chairman, under the rules of the committee, I ask unanimous consent to be able to distribute to members copies of two graphs that I intend to use during my questioning.

The CHAIRMAN. Without objection, so ordered.

Mr. BLILEY. Mrs. Clinton, first let me add my personal thanks for the job that you, the President and the Task Force have done in preparing your health care plan and beginning the national debate on the issue. I also want to thank you for the time that you and Ira Magaziner, who I wish wouldn't meet at 7 o'clock in the morning, have spent with the House Republican Task Force during the past several months.

Mrs. Clinton, like many others, we are currently working with a draft of the President's health reform proposal. To enable members to more fully understand this complicated plan, I would ask that you make available to the committee the Task Force quantitative working papers concerning financing, premium caps, actuarial

analysis of benefits, job impact and the actual health expenditure data.

Mrs. Clinton, the early evaluation of the President's plan by a wide range of experts, including economists and Members of Congress, is that the plan will not cost nearly as much as forecast and that the Federal budget deficit will dramatically increase as a result. That is because the success of the President's plan depends upon unprecedented cuts in the Medicare and Medicaid programs.

The cuts generate $285 billion in savings which represent almost two-thirds of the plan's financing. A cap is also placed on both private health insurance premiums and the Federal entitlements. When fully phased in, the cap is equal to CPI plus the annual percentage growth in population and your own data projects the annual growth in population at less than 1 percent or eight-tenths of 1 percent to be precise.

Mrs. Clinton, this chart to your left shows an international comparison of the average annual growth rate of health expenditures adjusted for inflation for the years 1985 to 1991. For example, in this period, German health expenditures actually grew by 2.87 percent above the inflation rate. The Canadian single-payer system grew at 4.8 percent above the inflation rate annually; and the British nationalized system grew at 4.07 percent above inflation. All of these countries show significant real annual increases above inflation.

In contrast to the experience of these nationalized systems, your cap on health expenditures allows real growth above inflation of less than 1 percent.

[The chart referred to follows:]

International Comparison: Average Annual Growth in Inflation Adjusted Health Expenditures

	Percent change 1985-1991[1]
Germany	2.87
United Kingdom	4.07
Japan	4.69
Canada	4.80
Italy	5.75
United States, under historical inflation conditions	6.08
United States, under fully phased-in Clinton proposed cap	0.80[2]

[1] Numbers are the percentage by which the increase exceeds the rate of inflation, as measured by the GDP deflator.
[2] Numbers are the percentage by which the increase exceeds the rate of inflation, as measured by the CPI.
Source: Organization for Economic Cooperation and Development, 1985–1991 comparison, Working Group Draft, September 7, 1993.

Mr. BLILEY. Mrs. Clinton, this data shows that nationalized single-payer systems such as Britain and Canada have not come even remotely close in limiting health expenditures to less than 1 percent above inflation. In fact, except for Germany, they have been growing at least at 4 percent per year above inflation, and even Germany has been growing at close to 3 percent annually.

In the case of Britain and Canada, we are talking about systems that explicitly ration care. My question is, how is the President's plan going to accomplish these extraordinary reductions in health care expenditures when even systems that ration care have not remotely approached these growth limits?

Mrs. CLINTON. Mr. Bliley, that is an excellent question. I really appreciate your asking that; because this is one of the crucial is-

sues that we have confronted. I hope the chairman may give us a little leeway on time, because it is such a critical inquiry. Let me start by saying that we anticipate realizing some substantial one-time-only savings over the next several years.

For example, we believe that insurance market reform, particularly in the non-group and small group market, will result in substantial savings. We believe that moving toward a single-form system will result in substantial savings. We can outline in more detail and will gladly do so the kinds of changes that we anticipate beginning to bring down our base level of expenditures.

Second, we think that the crux of achieving the kinds of savings and then stabilizing those savings over time into the outyears will result from changes in the way we organize and deliver health care. There are many examples of that around the country that we can point to.

Let me quickly mention a few. In the Medicare system, we know that Medicare expenditures vary greatly between different localities in our country without any difference in quality outcomes for the patients, largely because of differences in the way health care is organized in a particular area and because of differences in practice styles and decisions of doctors.

Currently there are no incentives in our fee-for-service reimbursement system that will move those decisions from being high-cost, inefficient ones toward being lower-cost, efficient ones, but we have substantial data to prove that if we change the way we provide incentives and reimbursement to providers, we will begin to reduce the costs that are currently continuing to escalate within our system.

In fact, the public-private model that we propose is if anything closer to Germany than to any of the single-payer national systems because it is a joint system of employer and government payments joined by individual contributions.

We believe there are some first-time savings that would be realized that would begin to reduce the base on which we are growing. We believe that we can change the internal dynamics of this system to move it closer toward more cost-effective, quality-driven delivery of health care. We believe further that we start with so much waste and unnecessary costs in the system, Dr. Koop has estimated maybe $200 billion worth that we can get this system stabilized and begin to reduce the increases in the rate of growth in a reasonable manner over time. We will be happy to share with you all of the data that you requested, all of our calculations, our economic models et cetera.

We have worked as hard on this question as any because you are right; it is the key. We believe we have enough leeway that if we decide a GDP growth rate as low as we think could be accomplished should be phased in more gradually we think we can do that, but we want to start with the firm conviction that there is waste in the system. There is better utilization that we can obtain in the system. There is better quality to be given the citizens of this country if we reorganize the way we deliver health care more efficiently.

[The following information was received:]

Question: How will the President's plan achieve cost containment of the magnitude described when other western nations have had difficulty achieving that level of constraint?

Answer: There are several sources of waste and inefficiency in the current U.S. health system that make us believe that we can rapidly slow the rate of growth in U.S. health costs.

First, experts estimate that as much as 25 percent of U.S. health care costs are spent on administration. Estimated savings for simplifying claims forms and from other measures to automate and standardize administration are between $4.2 to $5 billion. In addition, estimates for reducing hospital and physician salary expenses from simplifying billing functions range between $50 to $60 billion a year. As mentioned, these types of savings represent one time reductions in the spending base.

Second, as much as 25 percent to 33 percent of procedures in the United States are estimated to be marginally necessary or inappropriate. Although not all of these procedures can be eliminated, they represent almost $200 billion in marginal spending (assuming the lower estimate). If just one-fifth of these marginal procedures could be eliminated, we could save $40 billion a year.

Third, GAO has estimated that as much as 10 percent of medical spending represents fraud, waste and abuse. That is another $80 billion a year. Again, if just one-fifth of that could be eliminated, we would save another $16 billion a year.

Fourth, there will be savings from consumers choosing low premium plans within the alliance structure. Although these are difficult to estimate precisely, it was found in Minnesota that cost growth was reduced by approximately 6 percent when consumers switched from high cost fee-for-service plans to low cost managed care plans.

It is for all these reasons that we believe that our projected budgetary rate of growth is reasonable and realistic.

Mr. BLILEY. Thank you, Mr. Chairman.

The CHAIRMAN. The time of the gentleman has expired.

The Chair recognizes now the gentlewoman from Illinois, the chairwoman of the subcommittee, Mrs. Collins.

Mrs. COLLINS. Thank you, Mr. Chairman.

I too want to extend my heartfelt thanks that you are here before our hearing, Mrs. Clinton. As always, you bring a certain perspective with you that we learn from.

One of the things that I am concerned about right now is what I call medical redlining. The plan that we are looking at seeks to address redlining by health alliances by preventing States from drawing those health alliances in a manner that would discriminate against segments of the population on the basis of ethnicity or economic status.

How would the plan prevent individual health plans within the alliance from attempting to draw service areas that would in fact be relining against those kinds of situations?

Mrs. CLINTON. Congresswoman, we have worried about that because we do not want in any way to permit discrimination against providers or against patients. We think as part of the framework for determining what an accountable health plan is, there should be built-in protections against the kind of redlining and discrimination that you are talking about. It happens too frequently now in the insurance industry where people are eliminated from coverage because of who they are, if they have been sick or where they live or who they work for.

We think that by combining the changes in the insurance market that we intend to propose, plus protections built in so that accountable health plans will be offering their services to everyone who is in a geographic area and there won't be discrimination against people living in different areas, we will be able to protect against the discrimination dangers you rightly have pointed out.

Mrs. COLLINS. There is an area in my district, a health center just outside of downtown Chicago. It was closed for a long period of time and has been reopened. All the people in that neighborhood use that health center for primary and pediatric care. I wonder if that is the kind of center that would be classified as an essential provider center. More about that would be helpful to me.

Mrs. CLINTON. Yes, that is what we anticipate. Community health centers that serve unserved populations in urban and rural areas will be considered essential providers and they will become part of larger networks that will serve the entire population. But they will have relationships with hospitals and clinics and others so that the people who use the community health centers as the primary caregivers will therefore be able to be referred to a specialist or to a more complicated kind of care that they might need whereas now for too many people using the community health centers, they may go to the community health center for primary care, but because they are uninsured or underinsured they have no recourse except the emergency room as their entry into the additional health services that they may need. We do intend for those linkages to be developed.

Mrs. COLLINS. Finally, I have great concerns about power that insurance companies can gain in the plan as I have viewed it so far. I believe that during his speech the President noted that there are 1,500 companies that are providing health insurance in the U.S. today. But some reports I have seen suggests that the number of insurance companies may shrink to 100. If that happens that puts a lot of power in the hands of just a few insurance companies.

I had a personal experience with BlueCross BlueShield when I had to have cataract surgery. They decided that I couldn't have it done in the hospital even though my doctor wanted to do it for various medical reasons. Some clerk in the office said they weren't going to allow that and they overruled my doctor.

I am concerned about that kind of thing happening when you have so few insurers. I am wondering if there are going to be antitrust laws to keep these few from becoming an oligopoly and from having too much power.

Mrs. CLINTON. You are describing what is happening now, that insurance companies are often overriding doctors' opinions and making decisions based on insurance coverage instead of clinical judgment that the doctor would like to bring to bear. That is happening now.

We believe that moving toward the system that we have envisioned there will be less of that and in fact doctors will, we hope, regain some of the autonomy and authority that they have had to give up. The antitrust laws will still guard against monopolistic practices. We do want to make changes in antitrust to permit doctors and hospitals to have the same kinds of opportunities to organize to deliver health care that insurance companies have.

We want to have alternatives to insurance company-governed plans. We want to have the Catholic Hospital Association or the Mayo Clinic or the local medical school to have the same kinds of opportunities to join together with physicians to present services to the communities that will be covered and we hope that we can strike the right balance in the laws to permit that.

Mrs. COLLINS. Thank you very much.

The CHAIRMAN. The time of the gentlewoman has expired.

The Chair recognizes now the gentleman from Florida Mr. Stearns.

Mr. STEARNS. Thank you, Mr. Chairman and thank you for allowing me the courtesy of offering my questions, sir, as the ranking member of the Subcommittee on Commerce, Consumer Protection, and Competitiveness.

Mrs. Clinton, I want to congratulate you. I have watched Federal Reserve Chairman Greenspan show up at tables like that with a whole list of people helping him, so you are making a winning statement by showing up all by yourself. I want to compliment you on that.

My question goes a little further than my colleague from Virginia's question concerning the limit on insurance premiums to the CPI and to the population. When we place a cap on insurance premiums, in effect, limit the amount that doctors and hospitals can reimburse for hospital care.

My concern is that by imposing this limit, aren't we going to make the patients get less care and, in the end, this will lead to higher cost sharing on the part of the patient?

Mrs. CLINTON. We do not believe so. Let me give you a couple of examples of the great mass of evidence that would support our belief. First of all, there is such a wide disparity in health care costs right now in this country and there has been a great deal of research done to try to determine whether there are significant differences in quality or access between regions or communities that provide care at a higher price or a lower price.

What we have found in looking at all of the available research is that there is no discernible difference in quality between a lot of the high-priced care and more moderately priced care that is available in the country. At a hearing earlier today, I held up a booklet as just one example of the countless kinds of evidence we will share with you as the course of this debate goes forward which is a Consumers' Guide to Coronary Artery Bypass Graft Surgery put out by the Pennsylvania Health Care Cost Containment Council.

Before the President was even elected, Pennsylvania started to collect information to try to answer your question that you pose. If you look at this one simple booklet which outlines how much it costs at every hospital in Pennsylvania to perform this surgery, you will find that the cost ranges from $21,000 to $84,000. Then if you look at quality indicators, including the number of patients who died and who were expected to die given the severity of their illness, you will find that there is no correlation between the high cost and better outcomes. In fact, the lowest cost of the operation in one hospital has some of the best results.

What does this mean? It means that in just one State you have a range of costs for the same kind of operation from $21,000 to $84,000; yet there is no incentive in our current system to move those hospitals and doctors that charge more toward a more reasonable cost because they don't get penalized. There is no budget that they have to account for. They get all kinds of automatic passthroughs and if they aggregate all the different tests and proce-

dures, they get more money than if they say "This is the cost for a bypass in total."

We believe that if we could begin to reorganize the health care system to bring down the cost, we would not in any way undermine quality. In fact, we would enhance quality because we could afford in one State, and therefore across the country, to perform more operations like this for more people.

There are countless examples of this all over the country where we are not delivering the kind of quality health care for the price we are charging ourselves.

Mr. STEARNS. But in all deference to you, wouldn't you think it would be easier and more appropriate to bring it down through competition than through the government itself pushing and mandating and limiting?

Mrs. CLINTON. That is what we are doing. That is what we believe will work. We believe that through competition and market forces, hospitals will begin to make these adjustments so that they will move toward lower costs and be motivated at the same time to take a hard look at what they are doing.

We believe that there should be a Federal framework that sets forth certain kinds of guidelines about how this system should operate and then the government should get out of the way. But we also believe that given how much unnecessary cost there is in the current system, to get from where we are to where we need to be, that if we have some kind of premium cap and if we have some kind of budget targets, there will be a real incentive for hospitals and doctors and others to make the changes that so many others have done within the marketplace.

In the absence, though, of some kind of budgetary discipline to move some of our regions which are 300 percent more costly than other regions to anything like a national average in the time we need we think we have to have those extra tools to control costs. But we will be glad to talk about how they are defined and how they would be enforced.

The CHAIRMAN. The time of the gentleman has expired.

The Chair recognizes now the gentleman from Indiana, Mr. Sharp, and then the gentleman from California, Mr. Moorhead.

Mr. SHARP. Thank you.

Mrs. Clinton, you are to be highly complimented for the extraordinary work reaching out and learning and the rigor and thoroughness with which you have put together these proposals in what everyone agrees is one of the most complicated and profoundly personal issue we have ever had in the United States and as the President and Congress try to reinvent government, we have your model to follow for quality work, which is what the American people want from the Congress.

I think that leadership has put us in a position that we can truly do something about this issue, but I think the onus is now on us to follow that example, do the same kind of thorough, rigorous work, and most importantly consult with our people back home. You and the President have led in this in a critical way, because the lesson we have learned from catastrophic health insurance was, with a Republican President and a Democratic Congress committed to the same goal, we repealed the Act 1 year later and the reason

we did that is because of the massive failure in this country to bring into the process the very people who would receive the services and have to pay the bill. They were extremely confused and upset as a result of that exclusion.

So to make this work it is incumbent upon all of us to make a part of the process those people. I certainly applaud and support the broad goals that you and the President have outlined. We must provide health security for our people.

All of us have had hundreds of conversations with people who thought they were in good financial condition only to find their families were tormented by the absence of coverage or the loss of insurance. I will be submitting and talking with you and your Task Force about the circumstances of specific individuals, how they will be affected, how their business will be affected because we have to examine it through their eyes as we judge.

There are broader systems questions about how the system will work, the incentive structure. Let me put to you quickly one of the questions that will come up. There has been a lot of criticism by people that I don't know how they could have possibly analyzed the proposal, the question of bureaucratization, whether or not with the plans, the health alliances, a national board, that we might be adding new layers of bureaucracy.

Could you comment on that?

Mrs. CLINTON. Of course. We think that this will simplify the system and reduce bureaucracy because we are eliminating a lot of micromanagement and overregulation that comes from both public and private insurance systems right now. The health alliances as we envision them are to be the conduits for premiums that will be paid into them and then health plans will bid for the business by putting out their services and each of us individually will choose.

So under our plan most Americans would have their premiums paid from their employment as they are now. The employers' contributions and the employees' contributions would go into the health alliance. Then accountable health plans would be offered, much as the Federal employee health benefits plan works now with brochures and presentations, so that each of us individually would then choose the plan we thought best for us.

We don't envision much bureaucracy attached to that. We believe that every qualified health plan should be permitted to compete for premium dollars and we don't envision the alliance eliminating any health plan as long as it is qualified.

The National Health Board is a feature that is found in the Senate Republicans approach as well as the President's because we believe there needs to be some place to make a lot of the decisions about benefits. How they are actually defined in individual cases, when a treatment moves from being experimental to clinically provable, those kinds of decisions need to be taken out of this body, out of politics.

That is one of the roles we see for the national board as does the Senate Republican version. Again we don't anticipate a lot of extra bureaucracy or extra staff because there will be a lot of the staff already in place in HHS and elsewhere in the government that will be reporting to this board and the board will be acting like a board

of directors to be making decisions that will then be implemented by the rest of the government.

The CHAIRMAN. The time of the gentleman has expired.

The Chair recognizes now the gentleman from California, Mr. Moorhead.

Mr. MOORHEAD. Thank you, Mr. Chairman.

Mrs. Clinton, you have certainly been generous with your time over the last few months in coming to the Congress. I don't know of any witness who has come to as many different groups on the Hill as often as you have done. So some of these questions I am sure that you have been asked before.

The question that keeps coming up time and time again on the radio, on television, in the press, is the financing. I know you have been asked similar questions before. There was one broadcaster this morning, Charles Osgood, that said if you had spent $300 billion more in the next 10 years and would still be able to cut $400 million out of it, he has a car that will run on water that he would be happy to sell you. That is the kind of a sale you have to be able to make because the public is very concerned about that issue.

I was particularly struck with the comments recently made in a radio interview by a well know liberal economist Henry Aaron of Brookings Institute. He expects concern over the impact of the stringent restrictions on health care spending and what they would mean in the real world. Particularly at a time when new technologies are becoming more and more expensive and the number of very old Americans is dramatically rising he drew what I thought was a very down to earth analogy between spending limits and a family budget.

Dr. Aaron says you and your spouse have 10 children and your family budget is growing very rapidly because you are having more children and because the consumption of each child is rising. You are planning on having more children, but you are told that your budget cannot grow at all.

What are you going to do? We know that your spending on the children will have to dramatically decline. In terms of the health care system, Henry Aaron believes these budget limits in pure diagnostic services, in pure therapeutic services, he states that the real question is whether a sufficient quantity of services physicians now provide for patients are just purely wasteful and unnecessary and could be done away with with no loss of benefits. Could you please comment on that?

Mrs. CLINTON. Yes, I would be pleased to. I would just ask that the commentators and others look at examples in our country that are doing exactly what we think should be done on the national level. For example, Mayo Clinic has one of the finest reputations in the world. It has kept its cost increases for last year below 4 percent. That is inflation plus a very little bit at 3.8 or 9 percent.

If you look at the very large California pension and retirement system, it has kept its increases for the last 2 years even below that. If you look at Rochester, New York, which has a number of large employers and a dominant insurer in that community, they have kept their costs down.

If you look at the State of Hawaii which insures nearly everyone through an employer-employee system, they have kept their cost

increases and the total amount that they spend on a per capita basis for health care far below the rest of the country. I could go on and on because there are many isolated examples.

If you look at the Medicare system, you can see that in many communities that are relatively close together, like if you compare New Haven, Connecticut and Boston, Massachusetts, a Medicare recipient in New Haven costs the Federal Government about one half of what a Medicare recipient in Boston costs with no discernible difference in the quality of care.

There are so many examples in our Medicare and Medicaid systems and in our private system which show, I think conclusively, that if we better organize how we deliver health care, if we are smarter about making the decisions that should be made, if we eliminate the unnecessary tests and procedures that too often drive up the costs, if we root out the waste, and the fraud and the abuse, there is a very large amount of money that can be better allocated within the existing system. One of the things which has struck me repeatedly is the difference between the people who are commentators inside Washington and the people who run health care plans, hospitals, multi-specialty clinics, the Puget Sound Health Cooperative and many others around the country.

They say this can be done because we have been doing it without any kind of help, and we would like the rest of the country to get in and help us get it done right. So I am very confident that the kind of proposals we are putting forth are doable because I have visited and talked with people who have done exactly what we are proposing.

The CHAIRMAN. In accordance with the rules and the announcement of the Chair as to how they will be administered, the Chair recognizes the gentleman from Oklahoma, Mr. Synar.

Mr. SYNAR. Thank you, Mr. Chairman.

Mrs. Clinton, building upon who is right and correcting what is wrong is a message that Oklahomans and Americans have embraced overwhelmingly, But there are unique problems in Oklahoma and rural America. There are three characteristics.

One, they are older. Second, they are poor. And finally, they have probably the least leverage of anyone in the health care system to negotiate with providers as well as insurers. They fear that we won't be able to reverse the trend of deterioration of health care in the future with this plan and that they will be left behind to become second class citizens.

Describe for us the thinking of the Task Force with respect to rural health care and how it will better serve rural America.

Mrs. CLINTON. I would be happy to. I don't think the President and I could go home to Arkansas, which is next door to Oklahoma, if we had not paid a lot of close attention to rural health care which is something my husband has worked on since 1978 and 1979, because everything you have said is absolutely right.

In fact, a much higher proportion of rural residents are uninsured than urban residents. So we not only have the poverty, but less of a capacity for rural residents being able to get care. We want to do a number of things which we think will improve access to care and we have tried to strike the right balance between creating some kind of market in rural America, which is very difficult.

That is one of the real challenges, because there aren't that many providers who are willing to compete for the rural health care dollar.

First of all, we think the fact that insuring everyone will be a very big improvement in rural areas, because there will be a stable funding base. It will not just be the Medicare and Medicaid programs out there, but also uninsured that now will have funding streams. We will begin to create a marketplace. It won't be as big in small towns as in big cities, but there will be incentives for providers to offer care where before there weren't.

We believe that by creating alliance areas that will cover both urban and rural populations that the health care providers who want to compete for the urban dollar will also feel compelled to compete for the rural dollar. They will provide opportunities for rural providers and hospitals to become parts of networks so we will have connections between rural providers and urban providers we have never had before.

I have seen that already happening where some large hospitals in the State of Minnesota or some of the large providers there are now making linkages and providing contracts with rural providers. Second, we want to encourage more physicians and nurses to practice in rural areas and we want to do that through increasing the opportunities for them to pay back their loans and for having loan forgiveness if they will go into rural areas.

Thirdly, we want to improve technology between rural areas and urban medical care. I have seen extraordinary examples of that where we now have some programs in an experimental stage where you can be 400 miles from the medical school in a State like Texas and you can hold up an x-ray to a screen which then can be read in the medical school 400 miles away so that the specialist can be right there on the spot helping the rural hospital or the rural physician care for that patient.

And finally, I would say that part of what we believe is necessary is identifying community hospitals and clinics as essential providers because we know that during this transition unless we protect the providers and hospitals that are already in rural areas, they may go out of business and there may not be anybody there to take their place. So we have some funds targeted to keep them going so that they can be there when the urban hospital and the network of providers wants to contract with somebody so that we will have that essential service available in rural areas.

I think it is so important because I have visited, as you have, in so many rural communities that are getting less and less medical care than they used to have. It used to be 20 years they maybe would have a doctor or hospital and now they don't any more. We want to create the environment in which they will again.

Mr. SYNAR. Thank you.

The CHAIRMAN. The time of the gentleman has expired.

The Chair recognizes now the gentleman from Texas, Mr. Barton.

Mr. BARTON. Thank you, Mr. Chairman.

Mrs. Clinton, it is an honor to have you here. I come at this problem differently than most members. I am a registered professional

engineer. I believe that one must identify the problem before trying to develop a solution.

I have been involved in providing health care in a limited way in the past, in fact the last time I saw you in the late 1970's, I helped found and pay for a voluntary ambulance in Houston County, Texas to deliver people that needed health care to the local community hospitals and did so for 3 years. So I have not been involved as a professional physician like another member of the committee, but I have been involved in attempting in a limited fashion to provide health care.

I noticed in the President's book that you use the number of 37 million Americans who do not have health insurance. Interestingly, nowhere else is that number as high as it is in the President's plan.

The Census Bureau said that 32 million are uninsured at some point in time and 16 million as of 1987 had no insurance for the entire year. The Agency for Health Care Policy said that 24.5 million had no insurance for an entire year and 23.3 million were insured for part of the year.

The Harvard School of Public Health in 1992 said that 21 million were without health insurance for an entire year and the Congressional Research Service says that 35.4 million lack insurance at a given point in time.

Could you explain or provide to this committee where the number that is used in the administration's official documents of 37 million comes from?

Mrs. CLINTON. Yes. I would be happy to give you that information specifically. Let me perhaps point out some of the differences in timing and in analysis that would lead to different figures at different points in time.

If you are looking at the Census figure for 1990, there is a difference in terms of where we were when those figures were collected and where we are today. The growth you would build on top of the Congressional Research Service figure that you just had would get us closer to the 37 million. Others look at different points in time and they take a kind of monthly or rolling average as to how many people are out of insurance at a particular time and for how long.

It is our belief, based on all of those different kinds of estimates and how they are arrived at and the point of time at which they are taken and how they aggregate, that the 37 million is an accurate figure in large measure because it counts both those who are employed and uninsured, the family members of those who are employed and uninsured, and the unemployed and uninsured.

We will give you the specific calculations. The most recent work just completed was done by Families USA looking at every one of the statistics that you have cited plus trying to determine how to make it a understandable figure for people. They have pointed out that we are now in the process of seeing increasing layoffs and people losing jobs due to downsizing of the economy that accelerated in the last 2-year period, and that may account for the difference between the 35 and 37 million. There are people who are losing their insurance now every month who, unlike in the past, are not

being reemployed and therefore regaining insurance and their figure is that 2.25 million lose insurance every month.

Some may get it back in a month. Some may get it back in a year, but based on their projections they believe by this time next year, in the absence of our doing anything, we will be closer to 40 million uninsured. I will be happy to give you the statistics and the cites as to how we have calculated it.

[The following information was received:]

Question: What is the basis on which the number of uninsured has been estimated at 37 million?

Answer: This number is an estimate based on trending forward estimates from three "snapshots:" the 1992 (the most recent available) current Population Survey (CPS) conducted by the Bureau of the Census; the National Medical Expenditure Survey (NMES) conducted in 1987 by the Agency for Health Care Policy and Research (AHCPR); and the Health Interview Survey (HIS) conducted by the National Center for Health Statistics (NCHS).

The Current Population Survey estimated 37.4 million uninsured in 1992.

The Health Interview Survey for 1990 estimated 36.8 million uninsured in any 2 week period over the year.

The National Medical Expenditure Survey estimated 36.4 million uninsured during the first quarter of 1987.

Mr. BARTON. I would like to have of the numbers without insurance how many don't have it because they don't want it or how many desperately want it and can't get it because the Heritage Foundation and other groups have indicated that the number of Americans that don't have health insurance, but who do want it and can't get it is a much smaller number, somewhere between 10 million and 16 million.

Mrs. CLINTON. We will certainly get that for you. We have a difference in approach defining the problem. We think that those who say they do not have insurance and do not want it put an unnecessary burden on the rest of us because they are often young. They are often in their twenties. They are often people who don't believe they will ever be sick or be hurt.

Too often when something does happen to them, whether it is the unexpected automobile accident or the unpredicted illness, they, like every American, eventually get health care and then because they have been uninsured, the rest of us pay those costs.

We don't think the distinction between those who want it and can't get it or those who don't want it is a good one, because the lack of insurance puts burdens on the whole system and burdens the private sector in ways that we don't think should allowed to continue.

[The following information was received:]

Question: How many uninsured are expected in 1992?

Answer: Obviously, any projection of the number of uninsured will be subject to some error. Still, in 1991, the number was 35.4 million in the Current Population Survey.

In 1992, the number had grown to 37.4 in spite of the improvements in the economy which caused the number of employed to grow by half a million and the number of persons employed full time for the entire year to grow by over a million.

If the number of uninsured increases by the same amount as in 1992, the number of uninsured in 1993 will be over 39 million, or very close to the 40 million Mrs. Clinton used in her "off the cuff" reply to the question.

Perhaps improvements in the economy will cause the number of employed persons with insurance (as part of their wages) to increase rapidly enough to keep the number of uninsured from growing to 39-40 million. Firm estimates will be available in late 1994.

Question: How many of the uninsured are uninsured by choice?

Answer: This is a very difficult question to answer since no survey has successfully asked the uninsured about whether they had a choice of insurance which they turned down.

What little evidence we have, however, shows that very few actually turned down insurance when it was offered by their employer unless there was a substantial out-of-pocket premium involved.

In another sense, almost all the uninsured could purchase individual insurance if they chose to do so. Some 32.5 million persons in the March 1993 CPS indicated that they had insurance during 1992 from some source other than an employer.

Presumably most of the uninsured could similarly have purchased insurance through an agent or a business or professional organization from Blue Cross/Blue Shield or a commercial insurance company. In that sense, they chose not to do so perhaps because the coverage was expensive compared to the benefits they were likely to receive if they became ill.

Probably few of these persons were actually denied such insurance. The National Medical Expenditure Survey for 1987 showed that of the 36 million uninsured during the first quarter of 1987, only 37 percent investigated the cost of private health insurance and only 2.5 percent were turned down for insurance or allowed to purchase limited coverage. Thus of those who investigated the cost of insurance, only about 7 percent were turned down or limited in the type of health insurance they could purchase.

Most or all of the 33 million with individual insurance will welcome the new health plan because it will allow them to purchase insurance which is a much better value than the individual insurance they are now buying. Similarly most of the 37 million insured, the majority of whom work or have a family member who works, will now be able to have health insurance.

As I pointed out at the hearing, those who do not have insurance represent an unconscionable burden on those who currently have insurance.

Mr. BARTON. Thank you.

The CHAIRMAN. The time of the gentleman has expired.

The gentleman from Oregon, Mr. Wyden.

Mr. WYDEN. Mrs. Clinton, I am pleased that you and the President are going after the drug company and insurance ripoffs. Some of the drug companies think they have a God-given right to charge whatever they can get and some of the insurance companies only want you if you are healthy and wealthy.

I would like to ask you about the matter of the insurance premium limits because I think while the government proposal, your proposal clearly rejects explicit rationing as we heard from our colleagues, I think some of the insurance companies, when premium limits start, some of the insurance companies may try to go back door, sneaky and do unaccountable rationing.

The way it would work, say on a middle-class person, they might say well, you might normally get seven tests, but under this you will only get three or if your appointment is going to be at the beginning of the month, they will just put you off a few more weeks so they could do this sneaky back-door rationing. I know you are opposed to it and I have heard you say that, but I wonder if we could look at two other ideas in addition to the plan that could help us stop this sort of back-door approach.

One would be to say that when you have a closed panel, a health maintenance organization, that panel would also have to give people the right to go out side the panel and get what they want by paying a little bit more. That would be one proposal.

The second would be in the area of technology where we know that new products are fueling the cost increases so dramatically, whether we could look at a way to give the companies an incentive

to provide upfront information that would show why their product is superior to what is actually out there.

My question to you would be, I would just like to pursue both of those because I think that would be the way to lock out these insurance companies who are trying back-door, sneaky, almost de facto efforts to undermine what it is you are trying to do in terms of protecting consumers.

Mrs. CLINTON. Congressman, I am open to anything that stops sneaky, back-door attacks. I will sure look at both of those ideas. I think that the idea of having a referral out of a closed panel HMO or any organized delivery system is one that we should look at closely, because I think there is a real need on our part to be sure that referrals to specialists are as available as they need to be to all citizens, and I think you have a good idea and we will follow-up on both of those.

Mr. WYDEN. I appreciate that because I think the prism that you and the President are using is what does this mean for my family. That is what people all across this country are asking. I think that there are ways that we can balance cost containment and real freedom of choice and I appreciate your willingness to pursue these and look forward to working with you.

The CHAIRMAN. The time of the gentleman has expired.

The gentleman from North Carolina, Mr. McMillan.

Mr. MCMILLAN. Thank you, Mr. Chairman.

Mrs. Clinton, I want to add my welcome to you and express publicly what I have said to you in other meetings, which is my appreciation for the hard and effective work you have done in defining the problems and offering solutions. I have been a part of a Republican Task Force which has met with you and Mr. Magaziner on occasion at 7:30 Thursday mornings for the better part of 9 months, and I appreciate your willingness to listen.

I am not sure that you have heard everything that we have had to say, but I mean that constructively. I think we all understand the solution is going to require a broad, bipartisan base of support. I hope that before we are through with the dialogue on health care reform we will be able to achieve this support, and I mean that.

Some 20 years ago, I set up a comprehensive health care plan for a fairly substantial company. There were over 7,000 employees in that company, and I also worked a lot with small businesses in doing likewise. I am particularly concerned about how this impacts small and large business and how that interrelates with the very important issue of bringing the uninsured into universal coverage. So I want to ask you, if I may, a couple of questions on that.

Under the proposed financing scheme offered by the administration, corporations that choose to opt out of the regional health alliances and instead choose to operate under ERISA or Taft-Hartley alliances will be required to pay a 1 percent payroll charge over and above their health care costs into alliances of which they are not a part. Furthermore, these alliances do not have the protection which is afforded to smaller companies who are only paying 7.9 percent of their gross payroll for health care costs, so presumably their cost base in addition to the 1 percent extra charge could go well above that, which creates an imbalance among large and small corporations in that respect.

With that in mind, I am interested to learn your feelings on why any large corporation would bother to create an ERISA or Taft-Hartley alliance. In addition, for what purpose is the 1 percent payroll charge and to whom will that money go?

Mrs. CLINTON. The companies with whom we have spoken over the last months that would most likely want to continue to be self-insured believe that their costs either now are below the cap that you mentioned for employers or would be if they were in an insurance market with the kind of reforms we are talking about and if they were able to control their own costs. Those are the economic decisions that they are making in their conversations with us which lead them to believe that it is a better deal for them to continue to try to be self-insured.

We have pointed out, however, that there are certain system costs which they will be able to enjoy that would not be part of their premium base. The one that we are most concerned about is our academic health centers, the medical schools of this country that train our physicians, that provide a lot of the tertiary care at the most specialized level. Under our plan, these centers would have primary responsibility for serving as kind of quality guardians, if you will, for the entire health care system.

So the assessment that we would be asking the corporate alliances to make would go primarily to fund these academic health centers, because if we do not have some support from them to do so, they will be able to enjoy the benefits of all the services that the health centers are going to be providing without bearing any of the costs.

In our conversations, we have had a number of corporations tell us that even with the assessment that we would want them to pay into the alliance to help fund these purposes, they still believe they can deliver health care more cheaply. So it will be strictly an economic calculation that companies will make.

We will work very hard with them to make sure that if there are any features of the plan that would unfairly disadvantage them, that we will take a look at those; but until now we have not had a lot of opposition among those companies that are likely to have their own alliances.

The CHAIRMAN. The time of the gentleman has expired.

The Chair recognizes the gentleman from Kansas, Mr. Slattery.

Mr. SLATTERY. Thank you, Mr. Chairman.

Mrs. Clinton, I have been on this committee now for 10 years and I don't think I can recall another occasion when this many members on both sides of the political aisle have been so attentive for so long. You have truly tested our attention span here I suppose today, and I think it is a real tribute to you and to the President that both sides of the political aisle are so engaged on this issue. I think that it is a good sign for the months ahead as we engage in this very important debate.

I have three very specific questions. Number one, it is clear that you are attempting to give the States as much flexibility as possible in the implementation of this plan. I applaud that and I think that is a very good idea and extremely important for those of us who come from rural parts of the country where our Medicare reimbursement rates are lower than the national average.

I would like to know specifically know about Medicaid and what kind of specific flexibility you propose to give the States that will enable them to better utilize Medicaid dollars?

Mrs. CLINTON. Congressman, let me start by recognizing the extraordinary work that this committee and particularly the subcommittee chaired by Mr. Waxman has done over the years in trying to provide a medical safety net for millions of Americans through the Medicaid program. You have done so against great odds, and I think you are to be commended for looking out for those least able to take care of themselves in our health care system. But we believe that we want to merge the Medicaid system into the universal health care coverage system to end any kind of separate identification of Medicaid recipients. We want to blend the funds that would follow the Medicaid recipient to those that would follow you or me into a local alliance so that individuals would no longer be either discriminated against or identified as being a Medicaid recipient even though the State and Federal Government would continue to pay into the alliances the portion of the Medicaid cost that each Medicaid recipient would carry with them.

We think by eliminating the Medicaid program and integrating those recipients we will give better care to the recipients over the long run and realize the savings that will come from having more Medicaid recipients in primary and preventive health care networks and we believe that we will eliminate a lot of gross discrimination that currently exists against Medicaid recipients.

Mr. SLATTERY. My second question goes to the alliances and how they will be structured. Do you envision anything that would prevent States from contracting with private entities to perform the function that you envision alliances to do?

Mrs. CLINTON. No.

Mr. SLATTERY. So theoretically States could contract with an insurance company for example to provide the kind of function that you envision that would be performed by the alliances?

Mrs. CLINTON. Yes, but we would want the decision-making to be clearly the responsibility of either the nonprofit organization that the State might set up or the State, because ultimately the State would have to bear the responsibility.

Mr. SLATTERY. They could have a private entity that would be established to do the negotiating and do whatever administrative function that the State might designate that would be performed by the alliances?

Mrs. CLINTON. But under the direction of the State. It could be an intermediary kind of fiscal and negotiating function that would be performed, but the ultimate responsibility would have to rest at the alliance level.

Mr. SLATTERY. How much time do you think it will take for the President to present to the Congress the detailed programmatic changes in the Medicare program and Medicaid that will enable us to achieve the kinds of savings that you envision?

Before you answer that, let me just observe that Congressman Synar and I share a deep concern about how these cuts are going to affect rural areas, and our hospitals out there, I don't need to tell you, are extremely worried about the prospect of dealing with

cuts of this magnitude. I know that you are aware of that problem and you are committed to rural health care needs.

Could you answer the previous question about the time line we are looking at? Any hints you might have about what these programmatic changes might be would be appreciated, too.

Mrs. CLINTON. We expect to come forward with specific recommendations about areas where we can reduce the growth of Medicare. We are not proposing a cap that does not make the hard decisions. We think that we ought to try to specify both for purposes of clarity with the Congress, but also for providers where we think those reductions in the rate of growth can come so we will come forward with specific programs that we think can be delivered more efficiently, at less cost, and we will lay those out for you.

Mr. SLATTERY. Do you have any idea when?

Mrs. CLINTON. Within the next couple of weeks as we present the legislation.

[The following information was received:]

Question: What programmatic changes will you be proposing in the Medicare program?

Answer: We have proposed a series of provisions that can achieve significant Medicare savings when linked to cost reduction efforts in the private sector.

For Medicare, we are proposing $124 billion in savings by the year 2000, 23 percent of which would be gained by extending expiring authorities such as Medicare secondary payer provisions, the part B premium, and reductions in the hospital market basket which expire after fiscal year 1998. Another 27 percent of Medicare savings would be achieved through elimination of subsidies that will be unnecessary after health care reform, such as a reduction in indirect medical education payments, reducing the Medicare disproportionate share hospital adjustment, and lowering the Medicare secondary payer threshold for disabled workers.

The remainder of provisions involve a broad spectrum of Medicare program activities. I can assure you that they are designed to achieve savings without adverse impact on vulnerable populations, such as those in rural areas.

The CHAIRMAN. The time of the gentleman has expired.

The Chair recognizes the gentleman from Illinois, Mr. Hastert.

Mr. HASTERT. Thank you, Mr. Chairman.

Mrs. Clinton, we appreciate your being here and your openness, We also appreciate the work of Ira Magaziner and his staff over the last 9 months and the ability that we have had to carry out a dialogue and lay out our parameters. I think it has been a helpful situation and a good relationship.

There are some questions that we need to ask so that we can continue that work. In my district, I have been back and forth in town meetings, and constantly I have had people come up and say that they like the health care plan they are currently in, whether it is a BlueCross-BlueShield plan or if they work for Caterpillar Tractor. The question is, will they be able to keep the specific plan that they already have?

Mrs. CLINTON. We anticipate that in the vast majority of cases, the answer will be yes, because those who are currently delivering health care in a region are more than likely to be those who will form the accountable health plans that will be presented in a region, so they will have the same doctors, the same hospitals, the same features that they currently see as consumers now.

Mr. HASTERT. There will be two or three health plans in a region?

Mrs. CLINTON. Yes.

Mr. HASTERT. There may be more than that possibly. So if my pediatrician has joined up with one health care plan and my internist signs up with another health plan, do I have to make a choice there?

Mrs. CLINTON. Not necessarily, for the following reasons: Unlike what has happened until now where choice has been increasingly limited because doctors have been told who they can practice with if they expect to be reimbursed by this insurance company policy, we are going to end that kind of discrimination against doctors.

They will be able to join more than one plan and every doctor in a region will have the option of participating in a fee-for-service network in addition to any other plan that the doctor is in. So there will be many more options for doctors as well as for consumers.

I am not saying that every instance, every doctor will choose to be in the plan that will correspond to the doctor that you also want for another specialty, but in most communities, I think more likely than not a person like you or me or one of your constituents will be able join a plan that will have all the doctors you are accustomed to having. Where that doesn't happen, it will be because of the doctor's choice as to which plan the doctors choose to be in.

Mr. HASTERT. All doctors will sign up for all plans?

Mrs. CLINTON. They will all be in the fee-for-service network. Every doctor will be in that. We are going to require that. In addition, it will be up to the doctor. Some doctors may decide they don't want to practice in any other plans, but I would bet that doctors in addition to the fee-for-service network will sign up for at least one more plan, and maybe more than one, and it will be their option to do so.

Mr. HASTERT. Many people in my district go to the Mayo Clinic. They have a good record holding down costs. Last year, an unfortunate situation happened that, in the end, turned out fine. A young man on my staff was diagnosed as having cancer. He found a doctor at the University of Indiana, another State, that he was able to go to and was cured.

If you sign up with a plan in Illinois, will there be choices for people to go to the Mayo Clinic or the University of Indiana Health Center? Will you be able to do those things?

Mrs. CLINTON. Yes. That ties in with Mr. Wyden's question. We want there to be what is called in the insurance trade a point of service option. In other words, even though you are in a plan, whether it is a closed panel HMO or a fee-for-service network in Illinois, you should have the opportunity to be able to pick a specialist outside of that plan.

What we are looking at is how do we try to make sure that they are really true specialists. Nobody would argue with going to Mayo Clinic or with going to the University of Indiana. Somebody would have a choice to do that, because they would both be considered centers of excellence. We do want there to be some qualification so it is not just picking anybody, but picking the Mayo Clinic, the university, the academic health centers, which goes back to Congressman McMillan's point.

One of the reasons we need to be sure that everybody helps support these academic medical centers is so that they will be avail-

able for young men like the one you just mentioned, so that that will be an option.

Mr. HASTERT. Mr. Wyden talked about sneaky companies that are going to try to ration through the back door. One of our questions is what happens in Mr. Wyden's own State of Oregon, and how they deal with Medicaid recipients. Actually Oregon has made an explicit decision to ration care using a rationing list.

Oregon has brought thousands of more people into the Medicaid system, a bigger pool, but they have done it by rationing care. Is there a fear that health care in this country will be rationed in the future when our health care system will be growing by less than 1 percent?

Mrs. CLINTON. Congressman, let me answer that in two ways. I would argue that right now we have rationed care throughout this country. There are literally millions of Americans that don't have access to the same quantity or quality of millions of others.

I heard Dr. Koop say the other day that an uninsured person who enters a hospital with the same problem as an insured person is three times more likely to die than the insured person. That is a shocking statistic.

So right now because of our non-system of health care, we are rationing care all the time every single day. We believe by getting everybody into the system, making everybody in a sense carry their weight by having some funding that follows them, that there will for the first time be some incentives to reorganize care so that it is delivered more efficiently at higher quality.

I go back to my example of the coronary bypass surgery in Pennsylvania. If a high-quality bypass surgery can be done in one hospital in Pennsylvania for $21,000, then don't we need incentives in our system to convince those who are giving the same surgery for $84,000 to figure out what they are doing that costs so much that doesn't contribute one bit to the improved health of the patient and encourage them to start bringing their costs down? That is what we think will happen as we get more market and competitive forces at work but within a broad Federal guideline so that we protect against exactly the kind of problem that you are talking about.

The CHAIRMAN. The time of the gentleman has expired.

The Chair recognizes now the gentleman from Georgia, Dr. Rowland.

Mr. ROWLAND. Thank you Mr. Chairman.

Mrs. Clinton, I want to commend you and the President for the time and energy that you have spent in trying to resolve some of the problems that we have in our health care delivery system in our country. It has long been a feeling of mine, for over 20 years now, that we really have severe problems in the delivery of health care.

I don't think you will find many people in our country who will argue against the fact that we have the best quality care of any country in the world, but there is part of our system that is broken. There are millions of people who do not have access to the care and are not able to pay for the care; and that is the part of the system, it seems to me, that we need to look at in trying to fix.

Two Federal programs that we now have in place for the general public, Medicare and Medicaid, both of which have cost far more

than was anticipated at the time of their inception—this has been a particular concern of mine, because since I have been in the Congress and even before I came here, attempts have been made to hold down the cost of care under these programs.

In recent years, we have seen the Congress acting to try to reduce our budget deficit problem by focusing on Medicare to the extent now that we find the micromanaging of health care in our country to be something that those people who are providing the care find very difficult to deal with.

You are talking about having some savings under the Medicare program to help finance the new plan that you are going to put in place. In view of that, how would you explain that if you are going to try to have additional savings, there will not be additional micromanaging of the delivery of health care to the detriment of those people that receive the care?

Mrs. CLINTON. Dr. Rowland, I think that what we see is what you have seen throughout your career, and what your colleagues have seen; that is, that all too often the decisions about how care is delivered and to whom and at what cost are made on factors other than what is best for the patient. For example, what will Medicare pay for this, this and this if I add them all together, instead of trying to get the patient well?

As we look around the country, we can see that Medicare for many patients in different parts of the country is delivered at less of a cost with no difference in quality than you would find in a neighboring State or community. The difference, as you and your medical colleagues know, is that all too often the government has set prices for certain procedures which have not been in line necessarily with what a doctor's judgment would be, but determines often what the doctor does because that is how he gets paid. Instead of being paid on a per capita basis to take care of Medicare patients, he is paid on how many procedures he can run up.

It is human nature, if that is how you are going to be paid, that is how you run your office and that is how much care will increase.

In carefully comparing the costs of Medicare in areas that have better organized how they deliver care to Medicare patients—for example, Minnesota—we believe that we can actually deliver better care to more Medicare patients by decreasing the rate of growth in the way we are currently funding Medicare, taking that money, paying for a prescription drug benefit for older Americans and paying for the beginnings of long-term care for older Americans. I say that because if you look at the hospital and physician costs, if they range from one to three times the costs in different parts of the country, we know there is a lot of difference that can be made in there.

We believe if we can provide some better incentives in our Medicare system, which has done a good job getting everybody covered, but not in controlling cost increases, we can move more people in high-cost areas to do what they do in Minnesota or in Rochester, New York, to provide lower cost care for Medicare. And with the prescription drug benefits, we think in the long run we will save money, because too many older Americans leave a hospital with a prescription they cannot afford to fill, or they fill it and then self-medicate themselves.

You tell them they are supposed to take four a day. They figure if they take one a day it will last four times as long. They end up back in the hospital. That costs us more money instead of less.

So putting these pieces together is why we think we can deliver the kinds of savings in the Medicare system with increased benefits that will be better for older Americans.

Mr. ROWLAND. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. The time of the gentleman has expired.

The gentleman from Connecticut, Mr. Franks.

Mr. FRANKS. Thank you, Mr. Chairman. Madam First Lady, I too would like to commend you for your efforts in putting forth this health care reform package. You have truly given us, as Members of Congress, a major challenge.

I have just three questions:

One, during these very difficult times, why not cut health care costs before adding new health care benefits?

My second question would be, what aspects of tort reform would you embrace?

And my third question would have to do with illegal aliens. Although I come from Connecticut, we have a major problem in Danbury, Connecticut with illegal aliens. My question to you would be, how will they be dealt with in your proposal?

They represent an additional cost. They will have no insurance card, not being an American citizen, and they also represent an additional burden to our overall system.

Mrs. CLINTON. Let me try to answer those quickly within the time that we are allowed.

The question about cutting costs before benefits is a kind of chicken-and-egg issue, and we have looked at this very carefully, because certainly if there were a way to capture all the savings from the public and private system and sequester them and then take care of adding more people and benefits, that does seem to have a certain logical appeal to it.

The problem, as we look at it, is that the health care system consists of intermingled parts which affect one another, so until we get everybody into the health care system, we cannot control costs and we certainly cannot control cost-shifting. If we reduce the rate of increase in Medicare, but we don't provide the kinds of prescription drug benefits and long-term care, we will not be dealing with some of the continuing problems of the Medicare population that we think will help us save money in the long run.

Let me give you an example. Right now Medicare will pay the hospitalization bills, by and large, of a hospitalized recipient. If that person is seriously ill, but no longer needs hospital care, the family and the doctor are faced with a difficult problem. Do they keep them in the hospital at very high costs, even though they may not need to, or discharge them to be either sent home or put into a nursing home, where we don't provide any help for most families to be able to deal with that cost?

Instead, there are many people who are kept longer in hospitals under Medicare than doctors think they should because the doctors don't want to burden the families, because there is no alternative.

This is interrelated. As we provide alternatives to that, we will bring hospital costs down; we will get savings.

Furthermore, as we reduce the cost increases in Medicare and Medicaid, we cannot let the private sector simply add those costs to their insurance burden, or else businesses and individuals will find themselves paying even higher insurance premiums. So there has to be some reorganization within the private sector, which is why we think an employer-employee requirement, where everybody is in and where there are incentives for organized care, will help us prevent that cost-shifting. There are other examples of that.

Second, we believe in reforming the malpractice system, and we have recommended a number of steps that we would like to see the Congress take, including some kind of a required certificate of merit, so that before a malpractice lawsuit were brought, there had to be an independent doctor or an independent board which certified to the merit of that lawsuit.

We would like to see the health plans have some kind of alternative dispute resolutions, so that problems could be worked out before they get to court and cost a lot of money and put people to the time and worry of a malpractice case.

We also believe we should limit attorneys' fees in malpractice cases.

As to illegal aliens, we agree with you that the comprehensive health care benefits should not be extended to those who are undocumented workers and illegal aliens. We do not want to do anything to encourage more illegal immigration into this country. We know now that too many come for medical care, as it is.

We certainly don't want them to have the same benefits that American citizens are entitled to have. At the same time, when anyone in this country gets sick, they are going to come to our hospitals. If there is an outbreak of TB, we will treat all of those who might be involved, whether or not they are citizens.

So there will continue to be costs in the system that will have to be addressed in order to deal with the emergency and public health needs of illegal aliens, but we want to draw the line as to who is entitled to have that health security card, and that should be only our citizens and legal residents.

The CHAIRMAN. The time of the gentleman has expired.

The Chair recognizes the gentleman from New York, Mr. Manton.

Mr. MANTON. Thank you, Mr. Chairman. At the outset Madam First Lady, let me say we are honored to have you here today. I think you and your husband, our great President, are to be commended for bringing to fruition, hopefully very soon, the long-held ideal of universal health care.

I had the pleasure this Sunday of spending several hours with the President in my hometown in Queens in the City of New York, where he had a sort of a mini-town hall in a diner. Somehow diners are important in our social life in Queens, and also in our political lives.

We heard from people horror stories about the preexisting condition limitation, about people who because they are in a small pool in small businesses, pay extraordinarily high premiums; and one of my constituents who was there, who was a college-educated

woman, who had had a kidney transplant, had to impoverish herself and not be employed so that she could qualify for medical care and not be above the so-called poverty line. We recognize that this is very, very irrational.

I am privileged to represent a district which has one of the highest numbers of senior citizens of any of the 435 congressional districts. I wonder what we can say under this plan to our senior citizens who fear for their prescription medicine coverage and long-term health care, where the fear of having to spend down is something they find difficult to live with.

Mrs. CLINTON. I appreciate your asking that and reminding us about what we are doing here, and that is trying to help the people that you and the President visited with in the diner, and people like those who have come to every member of this committee over the years.

In working with the senior community in our country we have heard over and over again that, although they are grateful for Medicare, they still face overwhelming medical challenges with the cost of prescription drugs and the absence of adequate long-term care opportunities, particularly for home- and community-based care. In a community like the one you represent, where families like to try to stay together and help each other out, there is just no help.

I have visited so many homes and hospitals and community centers that ask me, why are we so penny wise and pound foolish. I was in St. Agnes Hospital in Philadelphia earlier this year, and they tried to run an adult day care center so families in the neighborhood that wanted to stay in the neighborhood, but had older relatives, could send family members to the hospital during the day while everybody was out working. But the cost was $35 to $40 a day, and many families couldn't afford that and could get no care or compensation; so they had to spend themselves or have their adult parents spend themselves into poverty so they could qualify for a nursing home.

They didn't want to be in a nursing home; they wanted to be at home. And they want to be able to spend the day at the local hospital where they can get good medical care. We didn't provide for that.

Under the President's proposal, prescription drugs and long-term care will, for the first time, become available to senior citizens; and we think that is a very important feature and one which will not only ease the anguish of a lot of older Americans, but save us money as we try to provide these services in a more cost-effective way.

Mr. MANTON. Thank you.

The CHAIRMAN. The time of the gentleman has expired.

The Chair now recognizes Mr. Greenwood.

Mr. GREENWOOD. Thank you, Mr. Chairman.

Welcome, Mrs. Clinton. Let me make unanimous the bipartisan sense of respect and admiration that we have all expressed for the work that you and the Task Force have done.

But beyond that, I think that after the good feeling that is engendered by your presence passes and we move on to some of the hearings and some of the markups, the sharp differences of opinion will emerge. I hope when it comes time to report this bill from the

subcommittee that I, as a Republican, can vote yes. And I recognize that we have a lot to hammer out in compromise before we can get to that point.

Uppermost among them is the concern that is probably expressed by our side of the aisle a little more frequently, concern for the impact of this proposal on employment, particularly on small employers and the ability of a small employer with relatively low wages, or labor-intensive businesses with small profit margins—restaurants talk about having margins of 1 or 2 percent—to comply with this.

Even at the highest rate of subsidy, therefore the lowest rate of contribution by the employer, 3.5 percent, there are employers who expressed to us that it isn't there, that there isn't 3.5 percent available to them; particularly in years when they are losing money, there are no profits whatsoever.

I would like you to respond to our concerns about what happens to those businesses. How should we deal with them. I know that there will be savings on the Worker's Comp side, maybe on the automobile side, that might accrue to their benefit; but it seems inevitable that when you impose a mandate such as this on employment, you have to have a downward pressure on employment. There have to be hundreds of thousands of decisions employees must make. Should I expand my work force beyond 50 or not? Should I bring on a part-time or temporary employee? All those decisions have to be reweighed in consideration of the cost of providing health care.

Mrs. CLINTON. Thank you. I want to assure the committee and particularly the Republican members who have been so helpful in this process that if we did not believe this was a net job increaser, we would not be here. We believe very strongly that removing the unnecessary and burdensome costs of health care from this economy will result in new and growing employment.

But having said that, I think I also want to stress how sensitive we are to the small business side of this. We come from the State of Arkansas where small business is the business economy in our State; and I come from a family where my father was a small businessman all of his life, and we never had health insurance, ever. We were just very lucky that no one got seriously ill during those growing-up years, because we never ever had health insurance. So I am very sensitive to what you are asking.

We have tried to be as careful as we can, but of course we want your advice and suggestions about this as we move forward. We think that there will be a great benefit for those small businesses who have been providing some kind of health insurance, and they are the majority. It is not a big majority, but they are the majority. And we think that if you look at the fast-growing job sector in our economy of small businesses, they are the ones more likely to be offering extra benefits.

The Small Business Administration has been doing a survey of small businesses around the country to find out exactly who is offering insurance, how much it costs, so we will have good data.

We also believe that as we lower the costs of health care to all sizes of business but particularly medium and large businesses, that will have a very positive impact on the economy. I have spo-

ken with the CEOs of major employers who have said that as we lower their burden, they are going to be putting that money into new hires, into more wages, into more profits, into more contracts with small businesses.

I would also add that in addition to helping the fastest growing small businesses and the small businesses that already provide insurance, we will be increasing health care jobs, a sector of the small business community that will take off like a shot because there will be so much more money there for things like home health care.

With respect to what will happen, if you look at Hawaii which, during the entire time that it has had an employer mandate, has had an unemployment rate below the national average and has had some of the fastest growing small business job creation, we certainly can't look to Hawaii as supporting the concerns that a lot of small business advocates have presented.

Also, if we look at the minimum wage increase over the past years under both Republican and Democratic Presidents, it has never had the kind of depressing impact on small business development that some people have feared. What we are talking about is much less than the usual increase in the minimum wage.

Finally, I would say that the 3.5 percent is a cap. Some small businesses will be paying 1 percent, 1.5 percent. For many small businesses that are on the margins, as you are describing, we would like the opportunity to know more about their individual circumstances. Based on the scenarios that we have been running, we think that this will be affordable, given the Worker's Comp decreases that we would like to foresee, the auto insurance health care decreases we would like to build in.

So, in general, we think there is no evidence on either a national level or a specific business sector level that would support the kind of dire concerns that some have voiced, but we want to be sensitive and work through that with you and others.

The CHAIRMAN. The time of the gentleman has expired.

The Chair recognizes the gentlewoman from California, Ms. Schenk.

Ms. SCHENK. Thank you, Mr. Chairman.

Mrs. Clinton, I want to add my thanks to you for the fundamental and substantive work that you have done in this. I know that I speak for everyone when I say that you have the admiration and the respect and the appreciation of the entire country. After all, you don't get paid to do this.

Before I ask my question, I am going to take the liberty of giving you a message from my mother because she said I must tell you that not since Eleanor Roosevelt has she so admired an American woman in public life, and this is from a woman whose admiration is not easily earned. I can tell her I delivered the message.

Mrs. CLINTON. I hope my mother is watching.

Ms. SCHENK. I would like to ask you about the section of the plan which deals with regulation of prices of new drugs. Most are developed not by the giant pharmaceutical companies but by the small biomed firms.

Under the plan, as I understand it, these breakthrough drug prices are going to be regulated by the National Health Board

through a breakthrough drug committee, and the committee would have the authority to make public declarations regarding the reasonableness of the initial launch prices for these drugs.

Some of the biomed executives have expressed concern to me that this kind of regulation would have a chilling effect on research and development in the industry, and of course these types of drugs not only have the potential for enormous cost savings in the long run but have enormous potential benefit for humanity.

Could you clarify for me sort of the rationale relative to pricing breakthrough drugs, and especially what consideration was given to motivating future research and development in the industry?

Mrs. CLINTON. This is one of the really difficult areas, because on the one hand we know that breakthroughs in medical research and pharmaceutical development can often be life-saving and certainly cost-reducing over the long run in terms of the medical costs.

We also anticipate, as I have said previously, providing a prescription drug benefit will greatly enhance the money going into our pharmaceuticals and drug manufacturers for research.

We also want to enhance the Federal Government's research capacity that will be done both by government agencies and in partnership with companies like those that are found in your district.

But I don't think anyone can any longer doubt that we do have problems with the pricing of drugs in this country; and what we are trying to do is to strike the right balance between encouraging and motivating research, but not permitting the public, either through government programs or through private insurance, to bear more than a fair share of the costs of any company recouping its research and development investment.

I don't know if any of you heard, as I did the other day on National Public Radio, the physician from the Mayo Clinic who was talking in great detail about a drug that had been developed for deworming animals that was determined to have some beneficial use for colon cancer in human beings. This physician at Mayo worked hand in hand with a drug manufacturer to make sure all of the testing was done so that it could be used for human beings. When it came on the market, the drug manufacturer started charging $6 a pill when you had basically the same drug being sold at six cents a pill for use in animals.

This physician at Mayo said this has got to stop.

Maybe you could say that was a breakthrough drug because it had a different use than it had, because it was no longer being used just for animals but being used for humans; but according to this well-respected doctor, there was no justification whatsoever for that increase in cost.

What we have tried to do is to strike a balance in which more money is going into the pharmaceuticals through the prescription drug benefits, through additional research dollars, but somebody has to have some way of saying, you cannot charge this much. What the National Board will do is not regulate prices, but publish information about what it considers to be a fair price for a drug, based on its cost of development.

If anyone has any better ideas about how to sustain the good development of drugs, have the drug manufacturers and the biomed research companies get a fair return, but somehow put a brake on

what are the unfair and, in many respects, totally unjustifiable costs that are still being asked in the pharmaceutical industry for us as the public and individuals to pay, we are open to that. But we believe strongly there has to be some method for trying to get a handle on these prices.

We will be glad to work with you further on it, because we don't want to inhibit research, but we don't want to reward what are unnecessarily high prices.

Mr. SWIFT [presiding]. The time of the gentlewoman has expired.

I recognize the gentleman from Ohio, Mr. Brown.

Mr. BROWN. Thank you, Mr. Chairman.

Mrs. Clinton, your work, especially with preventive care, has been particularly outstanding. Erskine Bowles, speaking the day after you addressed all of us, talked about losers that would come about in terms of the payroll payment. He said those companies, particularly, that can lose would be those that have a lot of young workers that have aggressively tried to ratchet down, if you will, health care costs and those companies that have real good wellness programs, aggressive anti-smoking campaigns, exercise on the premises, putting aside—if you would answer two questions.

How do you sell this program to those companies and to those employees when they will at least—in the beginning, at least, pay more; and second, how do we as a government provide incentives to those companies to continue the kinds of wellness programs they do?

You have talked about relying on employers for so much of this new health care program. How do we merge that together and help to provide those incentives?

Mrs. CLINTON. Congressman, I think that one of the reasons that costs will go up for some Americans is because they have benefited from the kinds of insurance practices that have eliminated other Americans from insurance, or priced it so high that they could barely afford it.

By that, I mean that many of the people who choose not to be insured or who get good rates for insurance are young, predominantly single, healthy Americans; and they right now are either paying less than the rest of us, because they are young and healthy, or are choosing not to be insured. They are among the 10 to 12 percent of Americans who will pay more for about the same kind of benefits. But the reason we think it is fair to ask them to do that is because if you look at the entire population, between 63 and 65 percent of Americans will pay the same or less for better benefits, about 20 or 22 percent will pay a little bit more for better benefits; and then we are left with this group that is young, and they have benefited from what is called experience ratings because they are young.

We have several alternatives, and what we have chosen to do is to say to young people, yes, you will pay a little more now to get guaranteed comprehensive benefits that will always be there for you, but as you age—which will happen whether you believe it or not—you will have the benefits of that because you will not then pay more for those same benefits.

We have a lot of young people around the White House, in case you haven't noticed, and some have come up to me and said, you

mean I am going to have to pay more? I said, yes, because we have an old-fashioned idea that young people and old people and sick people and well people all ought to be insured, because you will all get old and you don't know tomorrow whether you will get sick or have an accident.

We think the basic principles of fairness mean that everybody has to be in the system and that some young people now who pay less will pay a little bit more, but that is an investment that will pay off for them as they get older. We think if you look at the figures, we are being as fair as we can, but there are some who will pay more for about the same benefits.

The other point you make about prevention, there have been some employers who have really led the way, and have had some benefits in their insurance rates because of the programs that they have implemented. We want to see those programs implemented across the whole society through health plans that encourage primary and preventive health care and encourage better opportunities for people who want to give up smoking or who want to change their diet.

We think no individual employer can have anything but a limited effect on his employees, but that if we take what we have learned from employers who have been successful with prevention and we move it to the national level and to the accountable health plan level, we will have benefits that far outweigh what any individual employer could achieve for his or her employees.

Mr. SWIFT. The time of the gentleman has expired.

I noticed a note on the podium when I took the chair from Chairman Dingell. It says, "John, it is 50 years since your father introduced health reform legislation, and it is my fiftieth birthday today. Being here now is a great birthday present. May we meet with success for all Americans. Happy birthday, Mike Kreidler."

Mike, I recognize you for 5 minutes. I might note on your time, it is attributed to Vernon Jordan saying that anyone over 50 who wakes up without an ache or a pain is dead.

Mr. KREIDLER. Thank you, Mr. Chairman.

It is indeed a pleasure to be here and to be a part of this presentation today, Mrs. Clinton. I might point out a group that you mentioned earlier, Group Health Cooperative of Puget Sound is an example of what can be done with managed competition and managed care. It is an organization I began work with 21 years ago. For 20 years, they give you this little utility knife with their logo on it. I am a recipient of that for 20 years of service with Group Health.

I agree it is a good organization. I went to work for them because I had just completed a Masters in Public Health. When I started the Masters I wanted to work in health administration. Then-President Richard Nixon had proposed an employer mandate for health reform, and by the time I completed my degree, it was apparent that we weren't going to see the health reform President Nixon proposed at that time.

So it is a pleasure to be here for that reason, too.

I have two questions specific to the State of Washington. It is the only State right now that has been as bold in health care reform,

closely paralleling the administration, and also one that has an employer mandate as a part of that program.

It appears right now that the President's plan relies on major savings in Medicare, but it apparently does not try to change the basic fee-for-service structure of Medicare. Washington State has an enacted health plan that parallels that proposal, but the State plan would include Medicare in its managed competition system. Do you think States should have the option to structure Medicare around competing managed care plans, the way our State's plan would structure the system?

Mrs. CLINTON. Yes, I do. I think that by trying to encourage and move toward more organized care systems for Medicare patients, we would be doing a better job at a more efficient cost in preserving the quality of health care.

Too many Medicare patients now are being shut out of care because the existing fee-for-service networks will no longer take care of them at the price that Medicare will offer. I think many Medicare recipients would be happier and be more secure and be better cared for if we could move them into more managed care settings, and I applaud the State of Washington for moving in that direction.

Mr. KREIDLER. I was pleased at how the President's plan parallels our State plan, but one difference is that our State plan does not require all health care coverage to be purchased through health alliances. Our plan has an exemption for large firms, as the President's plan does, but it also allows smaller employers to buy coverage directly from plans without going through the alliance.

Why do you feel that all but the largest of purchasers should obtain coverage through alliances?

Mrs. CLINTON. Because we want to get the maximum purchasing power, Congressman. We have thought about this a lot.

Many employers believe that they could strike a good bargain for themselves. The problem is that if you don't have a large number of employers and employees in the purchasing pools, then you begin to have the kind of risk adjustment that works to the disadvantage of the whole system, and we are very concerned about that.

If we could build in adequate protections against that, we would be glad to look at options like what Washington has done; but on a national level, we are afraid that you would not have the kind of protection against what they call in the insurance trade "cherry-picking," and you would have younger, healthier people being hired by employers and, therefore, the employers being able to negotiate a better deal because there wouldn't be any protection against doing that. And we think that might cause worse kinds of outcomes for people than we currently have.

It is an area that we are open to discussing, but it is one that gives us a lot of concern.

Mr. KREIDLER. Thank you, Mr. Chairman.

Mr. SWIFT. Mrs. Clinton, Mr. Dingell is on his way back from the vote and he would like to close the meeting. Can you take a few more questions until he arrives?

Mrs. CLINTON. I would be glad to.

Mr. SWIFT. Thank you very much.

I recognize the gentlewoman from Pennsylvania.

Ms. MARGOLIES-MEZVINSKY. I add my voice to those who appreciate and respect what you have done. And welcome.

My question has to do with pap smears and mammograms. How do you reconcile the pap smear and mammogram regimen in the basic benefits package that falls short of the recommendations from the American Cancer Society and other women's health groups? In particular, I am concerned that women should receive annual or biennial pap smears and annual or biennial mammograms after 40, not 50.

Mrs. CLINTON. I am so glad you asked that because there has been so much misinformation and misunderstanding about this feature, and I am happy to have the opportunity to clarify that.

As you know, there are many insurance policies now that do not cover diagnostic services like pap smears and mammograms, which means that the woman bears the entire cost if she should obtain such a service. We have absolutely included them in the comprehensive benefits package. Mammograms and pap smears are covered services. That means that you can never be denied insurance coverage for those particular diagnostic tests.

What we have further done, and what we have done in line with a recommendation from the United States Preventive Services Task Force, which was created under the previous administration under the previous head of the National Institutes of Health, is to adopt their recommendation.

Their recommendation was that women over 50 should have a mammogram every other year. So what we have done is to say all women are covered. Every woman for whom any doctor believes it is medically necessary or appropriate can start at whatever age the doctor thinks she should begin. But for women over 50 the service will be completely free.

That means that if I belong to a health plan that has no copayment requirement, then I can start getting my mammograms and pap smears before I am 50 on a medically necessary or appropriate basis without any cost. If I belong to one where I have a $10 copay, that is all I will pay, but I can start any time before 50 and do it as many times as my doctor thinks is necessary.

But every single American woman, when she reaches 50, which is the age that was recommended by this very extensive task force that looked at all of the evidence, no matter what plan she is in, she will have that service absolutely free so the copayment will not be necessary. It will not count in any kind of deductible. It will be absolutely free. We think that is the right balance to strike.

If in the coming weeks and months the Congress believes that we should try to extend that free coverage below the age of 50, we will look at the cost of doing that. But I want to assure every woman—my mother-in-law has had a struggle with breast cancer over the last several years. I, like most women, have tried to do what I should do with respect to mammograms, and I paid the full costs because they were not a covered service in the past. So I take this very personally.

They will be covered. No woman will be turned away. They will be part of the guaranteed benefits package, and then for women most at risk, over 50, as a further inducement for women to come

in and do it, they will be absolutely free as part of the preventive services we provide.

Ms. MARGOLIES-MEZVINSKY. So if there is a family history, according to the doctor's wishes, they will be covered?

Mrs. CLINTON. If it is medically necessary or appropriate. That is a standard that would cover women with a family history or any kind of suspicious growths. It would not be in any way prevented or eliminated from coverage. If a woman believes it is appropriate, she will be entitled to have that service, and it will be covered.

Ms. MARGOLIES-MEZVINSKY. Will there be a compliance element involved here also? I feel that it isn't enough for an insurer of any sort to just have the service available.

The CHAIRMAN. The Chair advises that the time of the gentlewoman has expired.

Mrs. CLINTON. Mr. Chairman, I don't mind answering that.

The CHAIRMAN. If that is your wish, please.

Mrs. CLINTON. Because I think the Congresswoman has asked a very important question about ensuring quality and making sure that information is accessible to real people and not just folks who read medical journals.

We are going to do everything we can, and that is why I applaud your State so much, because this kind of consumer guide is the kind of information we will need and that will be part of the report card process. But I also believe that there will be a great interest in making sure that consumers get good information.

I would imagine that all kinds of consumer groups and maybe even a whole new industry will grow up to provide new information, so that every year when we make our choice about what health plan to join, we will be looking at all kinds of information that will help us make the best choice. And I will look at what is the quality, what kinds of treatment do they get and what kinds of outcomes do they have and how good a job are they doing.

That is my bottom line, and I think that that is what most Americans feel, as well.

The CHAIRMAN. The time of the gentlewoman has expired.

The Chair recognizes now the gentlewoman from Arkansas, Ms. Lambert.

Ms. LAMBERT. Thank you, Mr. Chairman.

As you can see, we members are into preventive care. If we run back and forth enough, we get our exercise for the day.

I would like to join my colleagues in their applause to you and to the present administration and the Task Force for taking on such a long-needed task in reforming health care in this Nation. Earlier in the spring, I introduced H.R. 2326. I have seen that included in your package which is a tremendous incentive to see health care, but also to see people taking the responsibility for health care and offering 100 percent deductibility for self-employed people.

I share your goals in looking for quality health care, affordable and available, but also lending itself to encouraging responsibility in the American public and taking on the responsibility of their own health care.

I have four questions, and I will be quick. You can choose whichever you would like to speak about, first being malpractice reform.

I see basically the proposal, or at least I feel, it hasn't gone far enough; it is an impediment, not really the strengthening that we need in order to increase defensive medicine that is being practiced in other areas. I would like to see if there are other proposals or additions that the administration would be amenable to as far as further malpractice reform.

I hear a tremendous amount from small, rural hospitals, the disadvantage they are put at because of CLIA regulations. I am hoping there are CLIA regulation reforms that will level the playing field or at least put these hospitals in a position where they can be capable of competing with the larger urban hospitals.

Next is protection of the client base for the small, rural hospital. Probably 15 to 20 years ago we saw a move to try and eliminate rural hospitals and concentrate more of the tertiary care, or the care, predominantly in urban areas where people felt they could care for more. Now we are looking at almost a 180 from that movement, which is to try and preserve some of the rural health care, because we find that not only does it provide a better quality of life but is more cost effective.

Many of my rural hospitals are frightened that they will lose the client base, that it will choose to go to the urban areas if they have the choice; and that the urban areas are mandated to be able to provide it in the same way the smaller hospitals are. So I hope there are precautions there.

Also, the State lines for the alliances: You, probably better than anybody in this room, understand my district. Very often, for obgyn coverage, whether it is dialysis or other things, many of my constituents have to cross the Missouri, Tennessee or Mississippi line; and how will the alliances be able to work together in order to provide those people that care?

Mrs. CLINTON. Congresswoman, I do understand your district. I have spent many, many days and happy times in that district, and often when I think about rural care, I think about your district because I know it so well. I will try to run down the points.

We think we have struck a good balance with respect to malpractice reform between trying to limit unnecessary, frivolous lawsuits, that do have a chilling effect and drive up the cost of defensive medicine, against the legitimate needs of victims who have to have some kind of compensation in order for them to have their life needs met. We are putting this forward as our best effort at trying to deal with real problems.

With respect to small, rural hospitals and CLIA, we look forward to working with this committee which pioneered the kinds of protections that CLIA put into law to make sure that where adjustments and reforms might be called for, they can be made in a thoughtful way. I know the committee will welcome your specific suggestions based on real-life experiences, because I, like you, have heard that sometimes when we try to do the right thing, we have unintended consequences, and some of those are particularly difficult in rural areas.

For example, hospitals and clinics no longer feel free to do a strep test because they feel they have to send it off and it takes 2 days and you could have beaten the strep infection if you could do it on site.

So those are some of the practical considerations that I think this committee will be very sensitive to.

With respect to State lines for alliances, we anticipate health plans crossing lines, and so the health plans will be coordinating services across State lines, just as they do now, so that even though you might be insured by an insurer in Arkansas, you are free to use your dollars in Memphis or another State. And we anticipate that that will become available even though alliances will be confined within States.

As a way for the States to be able to monitor their financial solvency and make sure that they are run correctly, we anticipate health plans bidding for business across State lines all over the country.

Ms. LAMBERT. If the alliances don't have the same programs, there shouldn't be a problem?

Mrs. CLINTON. No, there shouldn't be a problem because you will have providers joining together.

In east Arkansas, you will have, I would imagine, providers in Arkansas and Tennessee networking together to bid on business in both Arkansas and Tennessee; or you will have a Mississippi provider coming across the river to bid on business in southeast Arkansas. We anticipate that happening and think it will be very good for the kinds of opportunities for enhanced care in rural areas like your district.

The CHAIRMAN. The time of the gentlewoman has expired.

Mrs. Clinton, we want to express our thanks to you for a superb presentation today. This is, I would say, about the third or fourth time this month that I have had the privilege of listening to you, and I have learned a good deal each time. I want to tell you what a superb job I thought you did when you met with members informally in the learning session which we had earlier.

I thank you for your kindness today, and the appreciation we have with regard to the superb job which you have done explaining this. I can assure you of my personal support and that of many others in connection with your efforts to move this program forward. I believe it is a good one, and I believe it is necessary, and I believe it is in the public interest.

The Chair announces that the time that Mrs. Clinton had available to us expired 15 minutes ago.

So we express again to you our thanks for your kindness.

Without objection, all members will be permitted to insert opening statements in the record. The Chair advises that our time here has expired and there will be no time for further questions. If members choose, Mrs. Clinton has indicated that she and her staff would respond to questions, responses which we would not only make available to the members but would insert in the record.

Mrs. Clinton, we give you our sincere thanks for a superb performance today. We thank you and wish you well, and we will do our best to be of help to you.

Mrs. CLINTON. Thank you, Mr. Chairman.

The CHAIRMAN. The committee stands adjourned, subject to the call of the Chair.

[Whereupon, at 3:15 p.m., the hearing was adjourned, to reconvene at the call of the Chair.]

O

75-977 O - 94 (48)

ISBN 0-16-043569-2
90000
9 780160 435690